Emotional Care Of The Pregnant Woman

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SUMMARY Prenatal care affords an unparalleled opportunity, with a captive audience, to engage in prevention of primary mental health problems. Pregnancy and birth are family crises with much overt marital pathology and deviant parent-child relationships starting at this time. There is unfortunately little awareness of normal emotional reactions to pregnancy or of the pregnant woman's needs, and physician's attitudes and myths can perpetuate this. The author suggests a range of interventive methods including use of community resources and involvement of other professionals.

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PRENATAL CARE AFFORDS an ideal opportunity to prevent future emotional problems in child and family, in addition to the more readily identifiable medical complications of pregnancy. Faulty emotional attitudes, which could lead to a poor mother-child relationship, can be helped. During pregnancy the forerunners of later problems are evident: the 'vulnerable child syndrome', battered baby, and obviously unrealistic expectations for the unborn child which would make it impossible, for instance, for the family to accept a handicapped child.[7] We all see families where husband and wife barely cope with each other. The first baby creates jealousy and resentment in the husband, who sees his wife's time and energy diverted elsewhere. Successive pregnancies magnify the problem, with concurrent bitterness and anger. Frequently this anger is not directed towards the spouse, but displaced onto the children.

Myths About Pregnancy

Doctors tend to promote myths about pregnancy. One is that resentment of the pregnancy, mixed feelings, or vomiting are unquestionably due to some conflict on the part of the woman, or inability to accept her femininity. Another is that multiparas have an easier time psychologically, and do not need the solicitous concern that husbands and obstetricians give to primiparas. And yet research studies indicate that women on their second and third pregnancies feel even more ill at ease, anxious and harried[3] because they already have demanding little ones at home, and perhaps because husbands and doctors do not allow them to be dependent, a luxury usually afforded only to the primipara.

Normal Emotional Changes During Pregnancy

It is helpful to predict and discuss normal emotional changes with a pregnant woman, or with couples. I have been consulted by a number of men who confided that their wives had a personality change or became emotionally disturbed during pregnancy; in fact these are normal behavioral changes.

1. *Mood Swings.* These appear to be partly hormonal and not related to acceptance or rejection of pregnancy. On the other hand it is normal for the woman to have mixed feelings about the pregnancy, particularly initially.

2. *Increased Tension or Anxiety.* This is greater towards the end of pregnancy.

3. *Increased Introversion, Passivity and Dependency.* The woman turns in on herself, becomes more passive, dependent and childlike. She needs to be cared for and 'mothered' herself during pregnancy to prepare her to give unselfishly to the newborn child, who will give little back for a long time.

4. *Fantasies and Fears about the Unborn Child, Hospitalization and the Birth Process.* Women wonder, painfully, "Will my child be normal, or will I produce a monster?" Sometimes a woman will fantasize about having an abnormal child as a punishment for some kind of guilt, over an affair, for instance. If she does, a dreadful atonement is perceived, and she may be convinced of her innate badness and destructiveness, leading to multiple management problems with the child.

5. *Dwelling on Her Own Relationship with her Mother.* As term approaches she revives old memories about the kind of mothering she has had as a child; she wonders whether she will fare better or worse than her own mother. Women who had poor mothering themselves will have difficulties mothering their children. Histories of multiple fosterhomes, or orphanage placement suggest that one may be dealing with a deprived mother who will need much support and guidance in order to mother her children appropriately. This crucial area of mothering relationships can easily be explored with the pregnant woman.

6. *More Psychologically Open, Less Defensive.* There is increased potential for change, so that this is an ideal time for crisis intervention.

Knowledge of these general changes is important in

prenatal care, along with attempts to assess the woman's, and the family's, reaction and adjustment to this particular pregnancy. Motives for wanting a child, at conscious and unconscious levels, need to be considered.

Motives For Wanting a Child

1. *Ideal.* A child is desired as an expression of a strong marital bond.

2. *Society's Prescribed Role.* Childbearing is often seen as the only important role for a wife. The destructive potential of this stereotype has been explored in feminist publications.[6]

3. *To Prove Femininity.* This motive is present to some extent in almost all women. It explains why infertility is hard for a woman to accept, why adoption of a baby is fraught with emotion, with the woman needing to be an extra special mother to prove that she is feminine after all. It seems related also to the acute emotional crisis caused by premature birth,[2, 5] where the woman's inability to carry a baby to term may be perceived as proof of her lack of femininity.

4. *To Try to Keep Husband.* Having a child as an attempt to hold together a shaky marriage is seen frequently.

5. *To Raise Sense of Worth.* The mildly depressed woman with low self-esteem may hope another pregnancy will answer her difficulties.

6. *Competitive.* This is very frequent in neighborhoods of young mothers who may compete with each other about production of offspring.

7. *Child is Seen as a 'Creative Solution' to Boredom.*[4] Another baby may be seen as an answer to the empty nest left when the youngest child enters school.

8. *To Replace a Dead Person.* The baby may be viewed, unconsciously, as a replacement for a lost husband, sibling or parent. Unrealistic attitudes are created by the baby being placed in the dead person's shoes.

9. *As a Desperate Attempt to Obtain Love.* This unconscious motive is seen in very deprived unmarried mothers who hang on to the baby as their first personal possession expecting the baby to gratify their needs and often rejecting or illtreating the child when it becomes an active, striving toddler.

When adaptation to the present ongoing pregnancy is evaluated, this should be done within a broad psychosocial framework, considering any stress on the mother.

Adaptation to present pregnancy depends on:

1. *Attitude to Femininity and Motherhood.* These are based on the woman's relationship to her own mother. The daughter of a 'happy homebody' who enjoyed homemaking and raising children is likely to have few conflicts about following a similar pattern. The daughter of a frustrated intellectual woman resentful of the time spent caring for home and children will have much more difficulty with motherhood.

2. *Desire for this Pregnancy.* A woman may have ideal attitudes to motherhood, but may be opposed to this particular pregnancy. Grim and Venet[3] found that positive or negative wish for pregnancy was the most valid predictor of the outcome.

3. *Parity.* Increased parity brings more anxiety, more mixed feelings, yet less emotional support from significant figures.

4. *Experience with Previous Pregnancies.* Previous prematurity, stillbirth, miscarriage, difficult labor, or abnormal child will cause a great deal of tension related to the present pregnancy.

5. *Personality and Emotional Stability.* Active women tend to resent the increased girth and restricted movement of pregnancy, while their more passive sisters may enjoy it. Pregnancy may have little effect on ongoing mental illness, and some neurotics are reported temporarily better during pregnancy.

6. *Relationship with Significant Figures.* Loss of a significant relationship by death, desertion, divorce, or separation has a powerful impact on the pregnant woman with her needs for dependency and security. In the pared down 'nuclear family' of Western society a pregnant woman frequently has little support, and provision of additional help and guidance during pregnancy and postnatally may be vital.

7. *Social Factors.* Husband's loss of job, economic instability or a move are among the broader social factors which increase the stress on the pregnant woman.

Implications For Prenatal Care

Emotional reactions during pregnancy are universal, but vary depending on a large number of factors. Prenatal care affords an unparalleled opportunity, with a captive audience, to prevent psychiatric disability in child and family. The child psychiatrist often enters these situations years too late, and can do little but hope for limited change. Ideally, prenatal care should include discussion of her emotional changes, and needs, with the pregnant woman and her husband; assessment of her motives for, and adaption to, the present pregnancy, and identification of problem areas, and planned intervention, which might range among:

1. Home help.
2. Prenatal education classes.
3. Arranging discussions of pregnancy, and the management of the infant, with a mature woman, herself a mother. This might be an office nurse, a public health nurse, perhaps even the practitioner's wife.
4. Referral for marriage counselling.
5. Psychiatric referral.
6. Anticipatory referral, suggesting close supervision after birth, to the local public health resource.

Time spent in hospital after delivery also affords an opportunity both to evaluate, and start helpful intervention in possible problems. ◀

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